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ABSTRACT

Proceedings from three developmental disability workshops conducted for faculty from historically black colleges are presented. The workshops sought to implement strategies to increase the number and quality of minority professionals in the developmental disabilities service system and to develop a model for better relationships with the developmental disability system that may be replicated by historically black institutions. Three regional workshops for faculty were held in Alabama, Texas, and Virginia. Through them, a training manual was made available for faculty participants. The workshops were conducted by a mini-training team comprised of one person from the following disciplines/areas: psychology, physical therapy, occupational therapy, dietetics, nursing, social work, recreation therapy, special education, and mobility and sensory training. The workshops provided 15 hours of intensive preservice interdisciplinary training based on a training model developed by the Ohio University Affiliated Center for Human Development in Athens. Objectives of the workshops are outlined, and the schedules of the three workshops are briefly described. The keynote address for the Alabama workshop, which was presented by Yetta W. Galiber, is presented, along with the keynote address for the Texas workshop by Raymond F. Holmes, entitled "A Rubik's Cube of Service Delivery: Can We Solve the Puzzle?" and the keynote address for the Virginia workshop by Walter Barwick, "Linkers Do It Better Together--Networking: A Systematic Response for Developmentally Disabled Clients." Results of workshop evaluations and of pre- and post-tests assessing the knowledge base of workshop participants are presented, along with a sample evaluation form. (SW)

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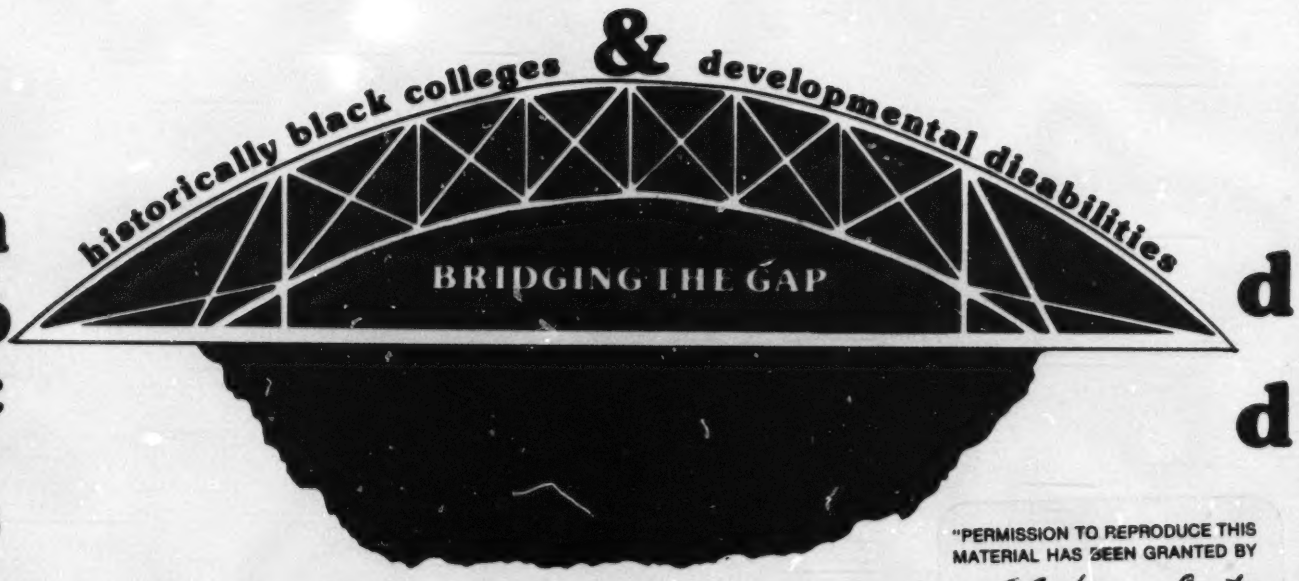
WORKSHOP PROCEEDINGS

MINI-TEAM TRAINING ON DEVELOPMENTAL DISABILITIES



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FOREWORD

The Alabama Center for Higher Education (ACHE) is a voluntary, academic consortium established in 1967 for the purpose of promoting interinstitutional cooperation among its members. Membership includes the seven, four year, historically black colleges and universities in the state as listed below; the Presidents make up the consortium's Board of Directors and the Vice Presidents/Deans of Academic Affairs serve on the Advisory Board of Deputies.

- Alabama A&M University
  Dr. R. D. Morrison, President
  Dr. Leon Frazier, Vice President for Academic Affairs

- Alabama State University
  Dr. Robert L. Randolph, President
  Dr. William S. Edmonds, Vice President for Academic Affairs

- Miles College
  Dr. W. Clyde Williams, President
  Dr. Theodore Debro, Vice President for Institutional Advancement

- Oakwood College
  Dr. Calvin B. Rock, President
  Dr. Mervyn Warren, Academic Dean

- Stillman College
  Dr. Cordell Wynn, President
  Dr. B.B. Hardy, Acting Academic Dean

- Talladega College
  Dr. Joseph N. Gayles, Jr., President
  Dr. C.T. Wright, Vice President for Academic Affairs

- Tuskegee Institute
  Dr. Benjamin F. Payton, President
  Dr. William L. Lester, Assistant Provost

One programmatic thrust of the consortium focuses on the development of cooperative strategies for the purpose of increasing the number of minority professionals in the state's Mental Health System. Recognizing the implications for replicability and a need to disseminate widely information relative to the model project, ACHE was awarded a grant by the Department of Health and Human Services' Administration on Developmental Disabilities to:

> Implement strategies for the purpose of increasing the number and quality of minority professionals in the developmental disabilities service system; and
>
> Develop a model for increased and improved relationships with the developmental disabilities service system which may be replicated by historically black colleges and universities both individually and collectively.

Three regional workshops were convened at residential facilities for the developmentally disabled for faculty from hbc's across the country who represent disciplines that have the knowledge/skills basic to solving problems unique to persons with developmental disabilities to include:

Psychology	Physical Therapy
Occupational Therapy	Nutrition/Dietetics
Nursing	Social Work
Recreation Therapy	Special Education

Workshop dates and sites follow . . .

Workshop I - March 31 - April 2, 1982
Brewer Developmental Center - Quality Inn
Mobile, Alabama

Workshop II - April 14 - 16, 1982
Austin State School - Villa Capri Motor Hotel
Austin, Texas

Workshop III - April 21 - 23, 1982
Southside Virginia Training Center - Ramada Inn
Petersburg, Virginia

Through these workshops, the development of a Training Manual which was made available to all faculty participants, these Workshop proceedings, and other follow-up strategies, ACHE has assumed a lead role in bridging the gap between historically black colleges and universities and the developmental disabilities system by providing the framework for this national model on collaboration.

Charlena H. Bray
Project Co-Director

Reynard McMillian
Project Co-Director

ACKNOWLEDGEMENTS

Significant to this national model on collaboration between the historically black colleges and universities and the developmental disabilities system are a number of linkages with cooperating agencies, institutions, and organizations without whose support the project could not have been successfully implemented.

- Southern Regional Education Board
  - Commission on Mental Health and Human Services
    Dr. Harold L. McPheeters, Director
  - Mental Health Manpower Development in the South
    Dr. Paul M. McCullough, Project Director

- Alabama Department of Mental Health
  - Office of Planning and Staff Development
    Mr. Ingram Gomillion, Director
    Dr. Ross Hart, Assistant Director
    Mrs. Ella Bell, Human Resources Specialist
  - Division of Mental Retardation
  - Alabama Developmental Disabilities Planning Council
  - Office of Personnel Services
    Mr. Henry E. Ervin, Manager
  - Brewer Developmental Center
    Mr. Lindsay W. Puckett, Director
    Mrs. Cathy Arnett, Assistant Director

- Texas Department of Mental Health and Mental Retardation
  - Austin State School
    Dr. B.R. Walker, Director
    Mrs. Gwyn Boyter, Director of Staff Services

- Department of Mental Health and Mental Retardation, Commonwealth of Virginia
    Dr. Joseph Bevilacqua, Commissioner
    Dr. Raymond F. Holmes, Assistant Commissioner, Mental Retardation
  - Southside Virginia Training Center
    Dr. Richard E. Buckley, Director
    Mr. Agenor L. Castro, Assistant Director, Community Affairs

- University Affiliated Facilities
  - Ohio University Affiliated Center for Human Development, Athens, Ohio
    Dr. Hilda Richards, Dean, College of Health and Human Services
  - Chauncey C. Sparks Center for Developmental and Learning Disorders, University of Alabama in Birmingham

WORKSHOP OVERVIEW

The use of a Developmental Disabilities Mini-Training Team is viewed as an effective method of orientating and demonstrating how a group of professionals from different disciplines can utilize their skills in concert. This approach is effective because developmental disabilities represent a consolidation of functional dysfunctions that require the expertise and training of several disciplines. A team of experienced trainers can transmit their skills to others less skilled and also orientate non-professionals to the nature and needs of the developmentally disabled in a realistic manner. No other method is more effective than actual demonstration in a relevant setting.

Hence, the Workshops were conducted by a Mini-Training Team comprised of one person from the following disciplines/areas: Psychology, Physical Therapy, Occupational Therapy, Dietetics, Nursing, Social Work, Recreation Therapy, Special Education and Mobility and Sensory Training.

The training sites were selected because each is a large residential institution for the developmentally disabled which provided a large pool of residents representative of the variety of dysfunctions presented by the developmentally disabled. Other reasons for the choice of sites were that: 1) workshop participants would be sensitized to a large target population to insure conceptualization of the nature and needs of the developmentally disabled; 2) the state of the art implies deinstitutionalization in the least restrictive environment, hence the nature of the institutions would be more vivid; and 3) participants would benefit from an administrative overview of the special concerns and considerations that is required if the problems of the developmentally disabled are to be grasped.

Therefore, a major program focus included guided tours of the respective facilities.

The workshops provided 15 hours of intensive preservice inter-disciplinary training based on a training model developed by the Ohio University Affiliated Center for Human Development in Athens.

Faculty participants from hbc's across the country are expected to return to their campuses with the primary purpose of continuing the process of demonstrating and orientation. It is projected that this spin-off effect will maximize the effects of the workshops. A continuing process will be put into effect that will encourage increasing numbers of Black students to select developmental disabilities as a career option.

Training Manuals were provided each participant to be utilized both as a training guide and resource manual.

WORKSHOP OUTCOMES

These workshops on developmental disabilities were designed to:

1. Develop an understanding of the DD concept;

2. Develop an understanding of PL 94-103 as amended by PL 95-602;

3. Develop an awareness of those professions/disciplines contributing to the delivery of services within the DD system;

4. Develop an awareness of the training and preparation needs for practitioners in the DD service delivery system;

5. Develop an awareness of funding sources that may assist in the development of personnel preparation programs;

6. Develop an awareness of the current and future manpower needs within the DD service delivery system;

7. Develop an awareness of local, state, and federal agencies serving the developmentally disabled; and

8. Develop an awareness of the current status of minority professionals in DD service delivery systems.

WORKSHOP SCHEDULE

Session I

A workshop pre-test was conducted by Dr. William D. Lawson, Project Evaluator, to determine the extent of the participants' knowledge of developmental disabilities and the various disciplines which impart knowledge and develop skills relevant for working with the developmentally disabled. Results of the pre-tests follow in a later section.

The video tape, "Davie Is Entitled" was shown to illustrate how the different professionals on a team work together. In working with Davie, a young developmentally disabled child, the team develops an Individualized Education Plan (IEP) for him. Significant is the intimate involvement of Davie's parents as an integral part of the team. "Davie Is Entitled" responds to the focal point of the workshops, how do professionals work together as a team to have the greatest impact on the developmentally disabled client. The video tape was produced by the Center for Human Development at Ohio University, Dr. Elsie D. Hehsel, Director.

Session II

For the Alabama Workshop, greetings were extended by Ms. Cathy Arnett, Assistant Director of Brewer Developmental Center and Mr. Henry E. Ervin, Manager-Office of Personnel Services, Alabama Department of Mental Health. During the Texas Workshop, greetings were extended by Dr. B.R. Walker, Superintendent of Austin State School, The Honorable Wilhelmina Delco, State Representative, and Mr. Volma Overton, President-Austin NAACP. For the Virginia Workshop, greetings were extended by Dr. Raymond F. Holmes, Assistant Commissioner for Mental Retardation-Virginia Department of Mental Health/Mental Retardation, Mr. A.L. Castro,

Assistant Director/Community Affairs and Mr. Jim Bumpas, Assistant Director/Administration, both from Southside Virginia Training Center.

Keynote speakers who were introduced by the Project's Co-Director, Reynard R. McMillian, follow.

Alabama	Mrs. Yetta W. Galiber Executive Director, Information Center for Handicapped Individuals, Inc. Washington, D.C.
Texas	Dr. Raymond F. Holmes Assistant Commissioner for Mental Retardation Department of Mental Health and Mental Retardation Richmond, VA
Virginia	Dr. Walter Barwick Deputy Director, White House Initiative on Black Colleges and Universities U.S. Department of Education Washington, D.C.

Guided tours of each training site were conducted by staff at each of the facilities. These tours were designed to provide the reality base to the workshops in addition to: 1) sensitizing the participants to the DD client; 2) showing how the professionals react with the clients; and 3) increasing participant awareness of the overall administrative problems that beset an institution. Special note is made of the tour during the Virginia Workshop in that the participants were shown a film of where the institution was 10 years before. This provided some measure of the progress that had been made as a result of legislation and various court ordered mandates.

Albert P. Brewer Developmental Center, a 200 bed residential facility in Mobile, is one of five such centers in the state which serves a 15 county area in Southwest Alabama. Brewer is operated by the Alabama Department of Mental Health.

Austin State School in Texas, an 800 bed facility, is one of 13 residential training facilities for mentally retarded persons in Texas, operated by the Texas Department of Mental Health and Mental Retardation. Southside Virginia Training Center provides training, therapeutic, and habilitative services for almost 900 residents. SVTC shares several services with Central State Hospital on whose grounds the majority of its buidlings are located. Both are operated by the Department of Mental Health and Mental Retardation, Commonwealth of Virginia.

Session III

Three concurrent workshops were conducted by the Mini-Training Teams comprised of faculty from five of the seven consortium member institutions. Each workshop covered the role, function, knowledge, and skills of the specified discipline/professions as they relate to professional practice in developmental disabilities settings, with a special focus on the following:

- the problem solving process;
- implications for curriculum development and training;
- the film - "Davie Is Entitled"; and
- the dialogue between the Mini-Training Team and participants.

All workshop participants attended each of the three sessions conducted by the Mini-Training Team, chaired by Dr. Theodore F. Childs, Chairman of the Division of Allied Health and Professor of Health Science at Tuskegee Institute.

•Mini-Training Team I

- Naomi Hunt, M.S. - - Physical Therapy
  Assistant Professor; Allied Health
  Department, Tuskegee Institute
- James H. Hicks, Ed.D. - - Special Education
  Chairperson, Special Education Department,
  Alabama A&M University
- Ann P. Warren, M.S. - - Nutrition
  Area Coordinator/Assistant Professor, Food
  and Nutrition, Alabama A&M University
*- Ethel Saunders, M.S. - - Nutrition
  Instructor, Food and Nutrition
  Alabama A&M University

•Mini-Training Team II

- Marie L. Moore, M.S., O.T.R. - - Occupational Therapy
  Assistant Professor/Program Director,
  Occupational Therapy, Tuskegee Institute
- Hoyt Taylor, Ed.D. - - Recreation Therapy
  Associate Professor/Chairperson, Recreation
  and Physical Education, Alabama State University
- Melvin Davis, Ph.D. - - Psychology
  Professor/Director of Institutional
  Research, Oakwood College

•Mini-Training Team III

- Aline B. Dormer, M.S. - - Nursing
  Associate Professor, Nursing Department
  Oakwood College
- John L. Parrish, Ed.D. - - Mobility and Sensory Training
  Chairman, Division of Education,
  Talladega College
- Francis Taylor, Ph.D. - - Social Work
  Associate Professor/Department Head,
  Social Work Department, Tuskegee Institute

Session IV

Dr. Francis Taylor, Mini-Training Team member in Social Work, led this session which focused on participants developing intra and inter-institutional plans. Participants worked together by states to prepare tentative plans for presentation during Session V.

*Ethel Saunders substituted for Ann Warren who was on maternity leave during the last two workshops.

Session V

Spokespersons from each state in attendance presented work plans that had been developed during Session IV. While the plans are not made a part of these Proceedings, they will be published and disseminated prior to the ending of this grant period (December 31, 1982). Faculty participants left each Workshop with a strong commitment to expand and increase program offerings related to developmental disabilities.

Dr. William Lawson, Project Evaluator, conducted the Workshop Post-Test, the results of which follow in a later section. Following the Post-Test, an anonymous evaluation of the workshop by participants was completed with results provided in a later section.

Keynote Address for the
Alabama Workshop

presented by

Yetta W. Galiber
Executive Director
Information Center for Handicapped Individuals, Inc.
Washington, D.C.

Most of us can remember being led in song at an elementary school assembly by a teacher who came out and either blew a pitchpipe or hit a key on the piano to give us the starting tone. I feel somewhat like that teacher this morning hoping my keynote will be close to yours-not pitched too high or too low. Above all we must remember what has brought us together. We must be aware of the challenge, the need, the opportunity we have before us. We can make harmonious music, if we heed each other's voices - if we determine that we will be a part of the solution to the dissonance that plagues poor black developmentally disabled persons in this country.

It is estimated that 10% of the worlds population or 450 million people are mentally or physically disabled. Three quarters are receiving no trained help whatsoever. One hundred forty six million of the disabled are children under the age of 15. Of that number six million are in North America. The incidence of disability is increased by malnutrition and disease in pregnancy and early childhood; but decreased by a lower life expectancy and higher rates of infant mortality. Malnutrition is the greatest single cause of disability which impairs both mind and body. Every year 250,000 children lose their eyesight through the lack of Vitamin A.

We, in the U.S. are faced with an additional dilemma of staggering seriousness. Our minority disabled citizens are suffering, are being

ignored, are dying physically and spiritually - are hungry, unclothed, unemployed, unsheltered, and completely unaware of the better life which is their right.

In the last two decades, in an effort to express our growing concern for handicapped persons, our society has thrust itself deeply into the area of personal rehabilitation. This concern has been evidenced nowhere more strongly than in legislation, resulting in programs designed to help the handicapped population. Regulations to these laws clearly require outreach so that blacks and other minorities can share in these rights and have their ways of life respected and incorporated into institutional and social service programs. However, as a result of the historical climate with its ever-present racism, blacks and other minorities are over-represented in every statistical indicator of socio-economic and health ranks and remain at risk with continuous and periodic episodes of acute anxiety attacks, depression, and personality disorders in an attempt to survive.

Members of black and other minority disabled groups are isolated from the mainstream of the service delivery systems and experience great difficulty in locating and accessing services. Social service professionals who are predominantly of the majority race, traditionally show concern for the problems of blacks and other minority handicapped persons, but most often this concern has been patronizing and self fulfilling of the needs of the white establishment rather than of blacks and other minority groups. Over the past ten years the developmental disabilities movement has been a growing part of American life. Families with developmentally disabled members have been making increasing demands for more appropriate services. Negative attitudes toward the developmentally disabled have been changing and society is beginning to recognize that developmentally disabled persons have the right to acquire education, job skills, and to lead as normal a life as

possible.

However, due to attitudinal, language, economic, geographical, and transportational barriers, blacks and other minority developmentally disabled individuals have been systematically excluded from obtaining the health and human services to which they are entitled. These groups have been further alienated from interaction with the service delivery system because of the influence of culture and sub culture dynamics, more specifically, beliefs, biases, perceptions and values.

In addition to these physical, economic and psychological barriers, there is a lack of genetic counseling and testing and a lack of accessible housing available to minority developmentally disabled individuals. These obstacles create a reluctance among blacks, and other minorities to interact with the majority society. Blacks and other minority developmentally disabled individuals also lack the knowledge of their rights and protection under Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Blacks and other minorities are not aware of the protection and advocacy systems as mandated by P.L. 94-103. I am the only black director of a protection and advocacy system in this country and know for a fact that most protection and advocacy systems have a dearth of minorty staff. Most protection and advocacy systems engage in little or no outreach efforts to minority developmentally disabled persons. It is also a fact that blacks and other minority developmentally disabled individuals are underserved or unserved by health and human service provider agencies throughout the country. As a matter of fact the health and human service provider agencies generally are also unfamiliar with the provisions of Title VI and Section 504 and are most often not in compliance with these laws.

There is a lack of bilingual personnel and a lack of data on the racial/ethnic backgrounds of the developmentally disabled clients served by provider agencies. Provider agencies do not institute outreach programs to encourage participation of blacks and other minority developmentally disabled consumers. And as you know, there exists a minimal number of black professionals trained in the area of developmental disabilities.

In 1980, the Minority Affairs Committee, of the National Association of Protection and Advocacy Systems, of which I am chairperson, influenced the Office of Civil Rights and the Administration on Developmental Disabilities to fund seven protection and advocacy systems to provide outreach services to ethnic minority developmentally disabled persons as follows: California Protection and Advocacy - Asians; Arizona and New Mexico Protection and Advocacy - Native Americans; Texas Protection and Advocacy - Rural Mexican Americans; D.C. Protection and Advocacy - Urban Hispanics; West Virginia Protection and Advocacy - Rural Blacks, and Maryland Protection and Advocacy - Urban Blacks.

These projects have made significant gains in identifying and assisting ethnic minority developmentally disabled individuals in obtaining appropriate health and human services. Materials have been developed in native languages, training has been provided to service providers, parents and consumers on legal and social entitlements.

But now we face additional major budget reductions in areas that severely impact handicapped persons particularly blacks and other minorities. In February 1982, the Childrens Defense Fund sponsored a conference on the proposed budget cuts that will drastically reduce services for children. Let me share with you information regarding the present health of black children in this country which presents the dismal circumstances of poor black children resulting most often in serious developmental disabilities.

The National Black Child Development Institute in their 1980 report on the status of black children found that black children are much more likely to suffer from poor health than the majority of their American peers. While poverty, unsafe housing, and poor nutrition expose many black children to harmful and hazardous conditions, their plight is compounded by systematic inaccessibility to competent health care. Together, these factors help to make many black children a population substantially at risk with no resources for assistance.

The statistics detailing the effects of deteriorating environments are particularly grim. The National Center for Health Statistics found that black infants are almost twice as likely as white infants to die before their first birthday. A black child has a 30% greater probability of dying by his/her fourteenth birthday than does a white child. Black children are more than 30% as likely as white children to die from fatal accidents. Black children who live in poverty will need to miss an average of two more days a year from school due to acute illness than will higher-income children. Indeed, should a black child live in deteriorating housing, he/she will have a 25% chance of having excessively high levels of lead in his/her teeth and blood.

Given the greater susceptibility of poor children to serious health complications, then, the relative inaccessibility of many black children to competent medical care is as disturbing as it is <u>disgraceful</u>. Over 40% of all black children, compared to 29% of whites, do not see a single physician each year, and even worse, 17% of all black children have no regular place of care despite their strong possibility of poor health. If one considers that 30% of all black children use only institutional care, the dissimilarities become more explainable. Families without a regular physician cannot receive the constant care that is integral

to effective preventive medicine. Black children, as a result, are much more likely not to receive basic immunizations against the most dangerous of childhood diseases. Less than half of all black children have received three polio dosages as recommended, and only 58% of black children have ever received an innoculation against measles. Understandably, then, black children are 25% more prone to measles infections than are their white counterparts.

No statistic captures better the hazard of being born black than does the exceptionally high incidence of infant mortality. Indeed, even though the 1976 black infant mortality rate of 25.5 deaths per 1,000 births continued a steady downward trend, white babies born twenty-five years earlier had the same chance for survival. More than any other factor, the delay or the absence of prenatal care accounts for high incidences of infant mortality since early health problems can go undetected without prenatal care. Black women are twice as likely as whites to never have prenatal care. While for each month of pregnancy, black women again are twice as likely to have not obtained prenatal care. Should a mother go without effective prenatal care, she will then be three times as likely to bear an underweight baby susceptible to infant mortality, prematurity, mental retardation and malnutrition. That over 13% of all black babies are born with low birth weights is therefore a dramatic reminder of the poor health that plagues many black children from the cradle on through adulthood.

The high rate of pregnancies among young black women poses a further health hazard. Due to inadequate health information and accessibility, black adolescent mothers are the group most likely not to receive prenatal care or else to delay it until the last three months of pregnancy. As many as one-fifth of all births to black teenagers therefore result in low

birth weights, a clear indication of the severe health complications of the crisis. It was an ironic tragedy that in 1981 the International Year of Disabled Persons, the present administration called for broad-based reductions of federal support for most of the primary service systems such as social security disability insurance, medicaid, medicare, vocational rehabilitation, developmental disability programs, mental health service and education for handicapped children. The reductions from prior budget estimates for these programs and other back up service delivery systems will be more than 55 billion dollars annually by 1986. The combined result of these proposed budget cuts on many disabled persons and their families will be devastating. Many disabled people who are now barely coping with the multiple strains on their lives will face new levels of psychosocial as well as family and financial difficulties. Significant numbers of disabled persons, especially blacks and other minorities will continue to "fall through the cracks." Health problems will increase as well as the frequency of hospitalization. More disabled persons will be unemployed and more will be forced into a welfare status. Greatly increased competition at the local and state level for much reduced program services will become a devisive factor in the social fabric of community life. Representatives of various vulnerable groups will be pitted against each other in a struggle to satisfy needs with more limited resources. The effect on the minority disabled given their intense vulnerability will likely result in much greater isolation and increased dependence.

In the present state of the nation, we are at a cross-roads in the field of developmental disabilities. The federal support that we have relied upon so heavily, has now begun to literally dry up. In its place is a new federalism of non involvement and restraint that I believe has strong overtones of racism. In the very near future, there will be even

less money, less technical assistance, and less in the way of broad-based rights and due process protections that were previously untainted by the strains of competing economic interests and hidden state agendas.

The state of this economy demands creative solutions. The black universities have the unique opportunity and responsibility to respond to the challenges of this pilot project. The black universities in the country must assume the leadership and provide the direction that the minority developmental disability movement now needs. The black universities must recruit and provide manpower, and become prime resources in the communities.

The movement needs black leaders with knowledge of developmental disabilities who are sensitive and committed to meeting the needs of black developmentally disabled persons. This knowledge is a must in the helping professions such as law, the healing arts, education, and social services. A valuable resource can also be found in the University Affiliated Facilities of which there are 35 in the country. In its October, 1976 report, the University Affiliated Facilities Long Range Planning Task Force pointed out, that interdisciplinary training is a basic essential in the effort to prepare leaders and other personnel to work effectively with the complex problems associated with mental retardation and other types of developmental disabilities. The black universities must begin to forge a network of organizations such as state protection and advocacy systems, state mental health administrations, state developmental disabilities councils as well as private industry, volunteer advocacy groups and coalitions of concerned citizens. Establishing and monitoring such a network of linkages between the various groups will, in effect, create a force that must be dealt with. Let's not rely on someone else's safety net, but instead create our own network - a spider web that

is light, flexible, yet possessed of enormous tensile strength. The black universities must become information centers for the assembling, ordering, and dissemination of information on developmental disabilities and become the "think tanks" for the minority developmental disabilities movement. The design of the developmental disabilities curriculum must serve not only students and researchers but parents, para legals, para professionals and cadres of volunteers. The black universities must reach out and make real and meaningful to all, the laws and regulations currently on the books that serve developmentally disabled persons. The black universities must be clearinghouses of information about resources and services that exist and become a focal point for the needs of the communities in which they reside.

It is vital that this project succeed, a success here will provide incentives and motives for other projects and replication of this one and the ripple effect will spread throughout the country. I have personally received letters from more than 48 black colleges indicating enthusiastic interest in participating in this type of program. The minority developmental disabilities movement will benefit from the leadership and expertise that can be and must be provided by you, the concerned members of the black educational community.

Keynote Address for the
Texas Workshop

presented by

Raymond F. Holmes, Ph.D.
Assistant Commissioner for Mental Retardation
Department of Mental Health and Mental Retardation
Commonwealth of Virginia

A Rubik's Cube of Service Delivery: Can We Solve The Puzzle?

HISTORICAL PERSPECTIVES

The record of how mental health concepts and services have been formulated and delivered to blacks and other minorities reveals how deeply an institution such as the mental health profession is embedded in general society.

In the south, there was generally little state provision for blacks. If slaves, they were taken care of by their owners, perhaps at less expense than when being hospitalized at the owner's expense. Eastern State Hospital at Williamsburg, Virginia, the first state mental hospital in which is now the United States, accepted free blacks from its founding in 1774. After the Civil War in 1869, a separate mental hospital exclusively for blacks, Central State Hospital, was established in Virginia, ultimately located in Petersburg, Virginia.

If no state hospital had room for an ill black person, he was often confined to jail or an almshouse. In the history of Central State Hospital in Virginia, the hospital's success was once measured by the jail's evacuation of blacks awaiting treatment. The north's record of accepting the black mentally ill was no better.

In 1840 the United States Government decided to enumerate the insane, partly out of concern over the rising number of asylum residents. This evidenced a strange discovery; the south had almost no insane blacks, but

as one moved north the rate of insanity increased. Jean Boudin, the French geographer and statistician, seized this information and extrapolated from it suggesting that cold climates were destructive to the mental health of blacks. In Louisiana only one out of 4,310 blacks was insane; in Virginia one out of 1,309; in Pennsylvania one in 257; in Massachusetts one in 44; in Maine the figure was, at that time, an impressive one in 14.

These statistics of 1840 were used for a number of years to support the idea of slavery.[1]

White vs Black Teacher Attitudes

1. Blacks tended to come from larger cities and obtained their degrees from urban universities;
2. Forty-seven percent of the black teachers were under 35 and had a higher probability of being married;
3. Blacks tended to be more satisfied with their teaching experience, but this decreased as length of teaching experience increased;
4. White teachers wanted more realistic professional training, while blacks wanted more knowledge of subject matters;
5. White teachers attributed job dissatisfaction to student lack of ability, poor student motivation, and discipline problems, while the black teachers emphasized large classes, poor equipment, inadequate supplies, and improper curriculum;
6. Black teachers tended to see the children as happy, energetic, fun loving, while white teachers viewed these students as talkative, lazy, and rebellious.

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[1]Willie, C. V. (ED.). Racism and Mental Health, University of Pittsburgh Press, 1979.

In general, black teachers tended to emphasize inadequate physical conditions under which they worked and the attitude of black teachers in this study suggests more optimism and job-mindedness than the attitude of white teachers.[2]

NATIONAL DEVELOPMENTAL DISABILITIES SURVEY

This study was designed to assess the extent and nature of the services offered to the developmentally disabled and particularly to minority groups by various service organizations or agencies.

A series of nationwide meetings with service consumers and parents of developmentally disabled persons across the United States was held, the vast majority being minority persons.

A sample of 1,200 out of 23,817 agencies were studied.

The findings suggest that minority persons are neither under nor overrepresented in the developmentally disabled movement. Minorities account for about 17 percent of the nations population, 23 percent of agency clients, 20 percent of their employees, and 17 percent of their board members. Minorities, however, were not fully represented in the highest category of employment - administration - although they are overrepresented among outreach category.

As might be expected, urban catchment areas contain the highest percentages of minorities. In turn, urban agencies have a higher proportion of minorities who are developmentally disabled. As suspicioned, any agency's minority staff is positively correlated with the proportion of minorities in the catchment area and the agency's location.[3]

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[2]Gottlieb, D. Teaching and Students: The Views of Negro and White Teachers, Sociology of Education: 37: 345-53, 1964.

[3]Morgan, S. The Developmental Disabilities Movement: A National Study Of Minority Participation, Department of Health and Human Services, #54-p-71193/9-02.

OVERVIEW OF COMMUNITY MENTAL HEALTH CENTER TRENDS

In October, 1963, Congress and President Kennedy approved and activated the community-based mental health center. The purpose of these centers was to replace state run institutions which had been in place for over 150 years.

760 facilities were created, located in every state and accessible to 50 percent or more of the population.

These federally funded community mental health centers were to provide comprehensive community-based care to individuals most in need, at greatest risk, and without regard to race, color, creed, or ability to pay. Their role has been influential upon the whole mental health system of care in the United States.

Since 1975 several salient community mental health center shifts in service delivery have been noted, for example:

1. Shifts have occurred from inpatient to outpatient care.
2. Between 1972-1976 federally funded community mental health centers increased by 78.9 percent, and their staffs grew from 24,655 to 48,466, a 96.5 percent increase.
3. Psychologists increased during this period by 151 percent, MSWs 122 percent, administrative and maintenance staff 199 percent, paraprofessional staff 31 percent, RNs by 69 percent and psychiatrists by 45 percent.
4. It is apparent from the data that community mental health center leadership is moving from doctoral to non-doctoral staff.
5. A new population of chronically mentally ill patients has been observed ranging usually in age from 18 to 35 with histories of schizophrenia, affective disorders, organic psychosis, alcoholism and drug abuse, and personality disorders.

Since these patients do not meet the criteria for involuntary commitment codes, they are admitted under voluntary procedures and have short periods of stay but often relapse and reenter community mental health centers at a great expense. Their behavior is prone to violence, and most, though help-seeking, are help-rejecting. Unfortunately, neither state hospitals nor community mental health centers are able to serve these individuals adequately.

If they wish to survive, community mental health centers must:

1. Develop closer relationships with clinics, hospitals, and medical centers;
2. Become more competitive in the private health care sector;
3. Continue to care for the indigent mentally ill, the poor and near poor; and
4. Become more adept at participating in third-party insurance programs, particularly Medicaid and Medicare.[4]

As budgets shrink, community mental health centers will be forced to decrease the size of their staffs, which may necessitate increased use of professionals rather than paraprofessionals.

A FEW TRENDS IN MENTAL RETARDATION SERVICES

Intermediate Care Facilities/MR as the predominant federal source of funding has had some undesirable side effects, in terms of the states' efforts to build a balanced array of alternative residential and support services for the mentally retarded. The consequences of cutting funding

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[4]Winslow, W. W. Changing Trends in Community Mental Health Centers: Keys to Survival in the Eighties, Hospital and Community Psychiatry: 33: 273-281, 1982.

for one element of a states' service continuum would be to slowdown development of community alternatives.

Community services, while usually more normalizing, probably will not be less expensive for the states to operate.

94-142, Rehabilitation Act probably will survive the present efforts by the Feds to water down their powers.

Home care subsidy for families may gain more favor in the various states.

There will be continuing efforts to determine cost benefits or programs, and the zero-based budgeting approach will gain more support.

Large training centers will begin to serve more of the medically mentally retarded disabled and serve as the temporary controlled environment for hyperactive mentally retarded persons.

More interagency efforts will probably be demonstrated as budgets begin to shrink.

In a longitudinal study of Pennhurst where the 1,155 clients in 1977 were to be deinstitutionalized by court order, the following has been found:

1. Placement of more handicapped individuals into the community can be done, but must be accompanied by an array of medical and behavioral support services, case management, parental involvement, and intense training during the first crucial months in the community.
2. Dissatistifed parents of institutionalized persons - especially in alliance with employee unions - can be a potent force against deinstitutionalization.
3. The Hearing Master process is a valuable means of providing a forum for parents and relieving some of their anxieties regarding community placement.

4. Phased deinstitutionalization should be accompanied by a thorough plan that involves the participation of all key actors.[5]

In order to begin the task of solving the Rubik's cube puzzle of service delivery, I have shared with you a historical perspective and commented briefly on current trends in mental health and mental retardation. In conclusion, I would like to be bold and suggest several recommendations which I believe will assist in the solving of this most complex puzzle.

RECOMMENDATIONS

1. Restate the purpose with clarity and integrity, fully recognizing the risks involved in this task.
2. Reorder priorities in ways that support the stated purposes.
3. Reformulate policies in ways that eliminate reliance on unexamined past practices.
4. Reexamine programs and look at them in terms of their consistency with statements of mission and concern for quality.
5. Reconceptualize programs in ways that reflect the needs of students, as well as competencies of faculties.
6. Reassess processes to eliminate that which is blatantly unfair, demeaning, and dehumanizing.
7. Reevaluate personnel in terms of current specific missions and tasks.[6]

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[5]Conroy, J. W.: The Pennhurst Longitudinal Study What Has Been Learned To Date? Prepared under contract of the United States Department of Health and Human Services, Office of Human Development Services, October 26, 1981.

[6]Kelly, J. Challenge and Choice: Business as Usual or Unusual Business. Paper presented at the meeting of the College of Preceptors (London), October, 1981.

Keynote Address for the
Virginia Workshop

presented by

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"Linkers Do It Better Together"
Networking: A Systematic Response for Developmentally Disabled Clients

A Frill has been defined as any innovative program which isn't your priority. Reagonomics has resulted in many essential programs being defined as frills. The realization that fewer resources will be available to fund critical human needs has in many instances altered the expectations of service providers. Without cooperation between service providers, service expectations will continue to decline. The Gloom and Doom Syndrome is found in epidemic proportions as educators, social workers, correction workers and others outside the Defense Department view the shifting of resources within the bureaucracy of the Public Sector.

The New Federalism is viewed by some observers as the Old Colonialism and the change from Categorical to block grants is perceived as positive or negative dependent upon your politics and/or perspective. Regardless of politics, Fatalism as a strategy is generally non-productive. If service providers view the situation as inevitable and irreversible and consequently fail to generate theories, establish plans of action and implement plans based upon existing resources; the situation for individuals with developmental disabilities will be fatal with the legacy of survival limited to a lucky few. As service providers, we have a responsibility to improve those odds; a responsibility which requires a change in fatalistic behavior. Cooperative programming, networking requires a change in service provision.

Change requires a disruption in the present pattern of behaviors. It involves risks as one is changing the known for the unknown. Change is viewed initially as the avoidance of pain and/or the seeking of pleasure. Change is needs based. Educators are generally resistant to change for change's sake. Networking, however, can be an effective response to not only those individuals who fall through the "safety net", but the one out of four individuals who is classified as developmentally disabled will be able to be better served.

The awareness of the problem creates the need for change. The generation of alternatives and the selection of appropriate alternatives created the means for change. Networking requires planned action.

Developmental Disabilities have been difficult to define because of the diversity of conditions which comprise this category. 94-142 and the Rehabilitation Act of 1973 attempt to describe the varied categories and to limit the number of individuals who are included under this category. Networking provides a means for continuity on the local level, a continuity of definition and service provision.

It is clearly indicated that developmental disabilities become most prevalent while the child is in the formative years, specifically in preschool - grade 4. Individuals who are people of color are oftentimes classified as mentally retarded, while the white child is called learning impaired.

The Rehabilitation, Comprehensive Serivces and Developmental Disabilities legislation called for defining Developmental Disabilities in terms of functional as opposed to categorical criteria and requiring States to target resources.

One out of each four persons in this audience could be potentially labeled developmentally disabled. One out of four persons could have a disability which affects one or more of your life's major activities which constitutes or results in a substantial handicap to employment and/or independent living. How does a state effectively target funds for individuals whose disabilities originate in childhood and are attributable to mental retardation, cerebral palsy, epilepsy, autism, specific learning disabilities, i.e. reading, encoding and certain other neurological conditions? The State can effectively do so with community input and networking.

Current issues evolve from problems in appropriately labeling students due to inadequate measures and conscious mislabeling, inadequate funding base for the population, and limited use of innovative techniques. The prognosis will be determined by the providers response to the challenge. Can networking really work?

Networking requires a change in behavior, a change agent who is aware of the need to creatively deal with limited resources to impact on a massive population, the developmentally disabled. A change agent, also, has the responsibility to educate the community as a first step in problem resolution. The change agent plays an advocacy role which interferes with the perpetuation of the Fatalism strategy.

The change agent in his advocacy role not only advocates networking, but the strategies which make networking a feasible way to creatively use limited resources. The Delivery system is a critical component of the networking process.

- Consortia, a composite effort by two or more colleges and/or universities is now a familiar means of delivering service to a specific population. The Developmentally Disabled might be serviced in such a manner.

- Partnerships might also be established between Colleges or with local education agencies who service the elementary and secondary students.
- Cooperative Agreements might be established with the private sector and/or other HUman Service Agencies who are committed to serving this population. Cooperative agreements are mutually beneficial arrangements which clearly delineate what human and fiscal resources are to be allocated, the benefits to accrue to each party, and the manner in which the service will be provided.
- Subcontracting of services can be a cost effective way of providing services to the Developmentally Disabled. Subcontracting on a consistent basis allows for appropriate staffing, continuity of service and creates an evolving expertise. Subcontracting might, also, be utilized in consortia, partnerships and cooperative agreements. The overlapping of service needs and strategies to meet those needs creates the climate for networking, establishing links. Linkers do it together, because to do otherwise is to create gaps in service.
- Multi-funding of programs, also, contributes to the positive climate for networking and enables the participants to provide a quality of service which would not otherwise be possible.

Some of the Federal departments or programs which inclu-e services to the disabled along with other groups are:

- Social Security Disability Insurance (SSDI)
- Aid to Families with Dependent Children (AFDC)
- Social and Rehabilitative Services
- Crippled Children's Services
- Health Services and Mental Health Administration
- Maternal and Infant Care
- Community Mental Health Centers
- Education for the Handicapped State Grants
- Developmental Disabilities State Grants
- Department of Housing and Urban Developments' Section 202 Direct Loan and Section 8 Rent Subsidy programs

- Mental Health System Act
- Title XX Social Services State Grants
- Vocational Rehabilitation State Grants
- Medicaid including the Intermediate Care Facilities for the Mentally Retarded funding for small community residence
- Rehabilitation Services Administration
- Bureau of Indian Affairs
- Office for Civil Rights
- Maternal and Child Health Service

Totaling billions of dollars estimate.

About 12% of the students in this country are handicapped or disabled.

In closing, remember: "Linkers Do It Better Together".

ANALYSIS: PRE AND POST-TESTS

In assessing the knowledge base of the workshop participants, a Pre-Test was designed by the Project Evaluation Team chaired by Dr. William D. Lawson. Other Evaluation Team members (also Mini-Training Team members) were Drs. James H. Hicks, Hoyt Taylor, and Francis Taylor.

Administered at the beginnig of Session I, the Pre-Test was designed to determine the extent of the participants' knowledge of developmental disabilities and the various disciplines which impart knowledge and develop skills relevant for working with developmentally disabled individuals. Upon completion of the 15 hour program design, a Post-Test was administered during Session V. Participants were asked to rate their knowledge base on 13 factors on a scale of 1 to 5 with 1 indicating very weak and 5 very strong. Included among those factors were knowledge of the meaning of developmental disabilities, special knowledge and skills your discipline/ profession offers to assist developmentally disabled individuals, mini-team approach to working with developmentally disabled individuals, and manpower needs in the service delivery system.

Tables 1,2, and 3 present the distribution of scores for the tests for each of the three workshops. An analysis of the differences between the means for the pre-tests and post-tests reveals significant changes in the knowledge acquired relative to the various factors that were measured. Relative to the mini-team approach to working with DD clients, the differences between the means within workshop groups ranged from 1.6 to 1.95, moving from a weak knowledge base to a strong one in each instance. Likewise signficant were the differences between means across groups on knowledge of manpower needs in the DD service delivery system whereby the differences ranged from 1.44 to 1.64 moving again from weak to strong.

With improvements on each of the 13 factors, the need for the lead role assumed by ACHE is further documented and emphasis areas for continued concentration are identified. At the same time, the data reveal that the purposes of the workshops were met.

TABLE 1.

DISTRIBUTION OF SCORES FOR PRE-TEST AND POST-TEST

ALABAMA WORKSHOP

KNOWLEDGE BASE		VERY WEAK (1)	WEAK (2)	MODERATE (3)	STRONG (4)	VERY STRONG (5)	TOTAL	MEAN SCORE	D*
MEANING OF DEVELOPMENTAL DISABILITIES	PRE-TEST		15.2%(5)	54.5%(18)	24.2%(8)	6.1%(2)	100%(33)	3.21	1.23
	POST-TEST			3.1%(1)	50%(16)	46.9%(15)	100%(32)	4.44	
HANDICAPS ENCOMPASSED BY THE LABEL "DEVELOPMENTAL DISABILITIES"	PRE-TEST		15.2%(2)	45.5%(15)	30.3%(10)	9.1%(3)	100.1%(33)	3.33	.86
	POST-TEST			9.4%(3)	62.5%(20)	28.1%(9)	100%(32)	4.19	
LEGAL BASES FOR SERVICES AND FACILITIES TO ASSIST THE DEVELOPMENTAL DISABLED INDIVIDUAL	PRE-TEST	6.1%(2)	30.3%(10)	42.4%(14)	15.2%(5)	6.1%(2)	100.1%(33)	2.85	1.31
	POST-TEST		3.1%(1)	18.8%(6)	37.5%(12)	40.6%(13)	100%(32)	4.16	
SPECIAL KNOWLEDGE AND SKILLS YOUR DISCIPLINE/ PROFESSION OFFERS TO ASSIST DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	3.0%(1)	6.1%(2)	39.4%(13)	33.3%(11)	18.2%(6)	100%(33)	3.58	.86
	POST-TEST			15.6%(5)	25%(8)	59.4%(19)	100%(32)	4.44	
VARIOUS DISCIPLINES/ PROFESSIONS WHICH FOSTER KNOWLEDGE AND SKILLS ESSENTIAL FOR ASSISTING DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	3.1%(1)	9.4%(3)	56.3%(18)	28.1%(9)	3.1%(1)	100%(32)	3.09	1.13
	POST-TEST			12.5%(4)	53.1%(17)	34.4%(11)	100%(32)	4.22	
MINI TEAM (SYSTEMS) APPROACH TO WORKING WITH DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	9.1%(3)	39.4%(13)	33.3%(11)	9.1%(3)	9.1%(3)	100%(33)	2.70	1.80
	POST-TEST			6.3%(2)	37.5%(12)	56.3%(18)	100.1%(32)	4.50	

Distribution of Scores for Pre-Test and Post-Test

Alabama Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental disability client population	Pre-test	3.2%(1)	22.6%(7)	54.8%(17)	16.1%(5)	3.2%(1)	99.9%(31)	2.94	1.29
	Post-test			16.1%(5)	35.5%(11)	45.2%(14)	99.9%(31)	4.23	
Local agencies serving the developmentally disabled	Pre-test	9.1%(3)	21.2%(7)	42.4%(14)	9.1%(3)	18.2%(6)	100%(33)	3.06	.94
	Post-test		9.4%(3)	21.9%(7)	28.1%(9)	40.6%(13)	100%(33)	4.00	
State agencies serving the developmentally disabled	Pre-test	9.4%(3)	15.6%(5)	43.8%(14)	25%(8)	6.3%(2)	100.1%(32)	3.03	.94
	Post-test		3.1%(1)	25%(8)	43.8%(14)	28.1%(9)	100%(32)	3.97	
Federal agencies serving the developmentally disabled	Pre-test	9.1%(11)	33.3%(11)	45.5%(15)	12.1%(4)		100%(33)	2.61	1.13
	Post-test		9.7%(3)	29%(9)	38.7%(7)	22.6%(7)	100%(31)	3.74	
Funding sources that may assist in the preparation of personnel for working in the developmentally disability service delivery system	Pre-test	12.1%(4)	39.4%(13)	36.4%(12)	12.1%(4)		100%(33)	2.48	1.36
	Post-test		6.3%(2)	31.4%(12)	34.4%(11)		100.1%(32)	3.48	
Manpower needs in the developmental disability service delivery system	Pre-test	9.1%(3)	36.4%(12)	33.3%(11)	18.2%(6)	3%(1)	100%(33)	2.70	1.64
	Post-test			18.8%(6)	28.1%(9)	53.1%(17)	100%(32)	4.34	
Job classifications in the developmental disability service delivery system relevant to your discipline	Pre-test	9.1%(3)	30.3%(10)	45.5%(15)	12.1%(4)	3%(1)	100%(33)	2.70	1.68
	Post-test			6.3%(2)	50%(16)	43.8%(14)	100.1%(32)	4.38	

D* = Difference means for pre-test and post-test

TABLE 2.

DISTRIBUTION OF SCORES FOR PRE-TEST AND POST-TEST

TEXAS WORKSHOP

KNOWLEDGE BASE		VERY WEAK (1)	WEAK (2)	MODERATE (3)	STRONG (4)	VERY STRONG (5)	TOTAL	MEAN SCORE	D*
MEANING OF DEVELOPMENTAL DISABILITIES	PRE-TEST	3.7%(1)	3.7%(1)	66.7%(18)	18.5%(5)	7.4%(2)	100%(27)	3.22	.89
	POST-TEST			17.9%(5)	53.6%(15)	28.6%(18)	100.1%(28)	4.11	
HANDICAPS ENCOMPASSED BY THE LABEL "DEVELOPMENTAL DISABILITIES"	PRE-TEST	3.7%(1)	14.8%(4)	40.7%(11)	37.0%(10)	3.7%(1)	99.9%(27)	3.22	.78
	POST-TEST		7.1%(2)	14.3%(4)	50.0%(14)	28.6%(8)	100%(28)	4.00	
LEGAL BASES FOR SERVICES AND FACILITIES TO ASSIST THE DEVELOPMENTAL DISABLED INDIVIDUAL	PRE-TEST	11.1%(3)	29.6%(8)	37.0%(10)	22.2%(6)		99.9%(27)	2.70	1.05
	POST-TEST	3.6%(1)	3.6%(1)	35.7%(10)	28.6%(8)	28.6%(8)	100.1%(28)	3.75	
SPECIAL KNOWLEDGE AND SKILLS YOUR DISCIPLINE/ PROFESSION OFFERS TO ASSIST DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	11.1%(3)	14.8%(4)	48.1%(3)	22.2%(6)	3.7%(1)	99.9%(27)	2.93	1.00
	POST-TEST	3.6%(1)	3.6%(1)	14.3%(4)	53.6%(15)	2.5%(7)	100.1%(28)	3.93	
VARIOUS DISCIPLINES/ PROFESSIONS WHICH FOSTER KNOWLEDGE AND AKILLS ESSENTIAL FOR ASSISTING DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	11.1%(3)	22.2%(12)	44.4%(12)	22.2%(6)		99.9%(27)	2.77	1.30
	POST-TEST	3.6%(1)		32.1%(9)	46.4%(13)	17.9%(5)	100%(28)	4.07	
MINI TEAM (SYSTEMS) APPROACH TO WORKING WITH DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	18.5%(5)	44.4%(12)	29.6%(8)	7.4%(2)		99.9%(27)	2.19	1.95
	POST-TEST		3.6%(1)	10.7%(3)	53.6%(15)	32.1%(9)	100%(28)	4.14	

Distribution of Scores for Pre-Test and Post-Test

Texas Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental disability client population	Pre-test	11.1%(3)	29.6%(8)	33.3%(9)	22.2%(6)	3.7%(1)	99.9%(27)	2.77	1.04
	Post-test		11.1%(3)	22.2%(6)	40.7%(11)	25.9%(7)	99.9%(27)	3.81	
Local agencies serving the developmentally disabled	Pre-test	11.1%(3)	29.6%(8)	29.6%(8)	25.9%(7)	3.7%(1)	99.9%(27)	2.81	.90
	Post-test	3.6%(1)	7.1%(2)	21.4%(6)	50%(14)	17.9%(5)	100%(28)	3.71	
State agencies serving the developmentally disabled	Pre-test	7.4%(2)	33.3%(9)	37%(10)	18.5%(5)	3.7%(1)	99.9%(27)	2.77	.93
	Post-test	3.7%(1)	7.4%(2)	22.2%(6)	48.1%(13)	18.5%(5)	99.9%(27)	3.70	
Federal agencies serving the developmentally disabled	Pre-test	11.5%(3)	34.6%(9)	34.6%(9)	19.2%(5)		99.9%(26)	2.62	.88
	Post-test		10.7%(3)	42.9%(12)	32.1%(9)	14.3%(4)	100%(28)	3.50	
Funding sources that may assist in the preparation of personnel for working in the developmentally disability service delivery system	Pre-test	25.9%(7)	51.9%(14)	18.5%(5)	3.7%(1)		100%(27)	2.00	1.17
	Post-test	3.6%(1)	25.0%(7)	32.1%(9)	28.6%(8)	10.7%(3)	100%(28)	3.17	
Manpower needs in the developmental disability service delivery system	Pre-test	25.9%(7)	44.4%(12)	14.8%(4)	14.8%(4)		99.9%(27)	2.19	1.44
	Post-test	3.7%(1)	7.4%(2)	11.1%(3)	59.3%(16)	18.5%(5)	100%(27)	3.63	
Job classifications in the developmental disability service delivery system relevant to your discipline	Pre-test	40.7%(11)	29.6%(8)	11.1%(3)	14.8%(4)	3.7%(1)	99.9%(27)	1.96	1.58
	Post-test	3.6%(1)	14.3%(4)	17.9%(5)	53.6%(15)	10.7%(3)	100%(28)	3.54	

*D = Difference between means for pre-test and post-test

TABLE 3.

DISTRIBUTION OF SCORES FOR PRE-TEST AND POST-TEST

VIRGINIA WORKSHOP

KNOWLEDGE BASE		VERY WEAK (1)	WEAK (2)	MODERATE (3)	STRONG (4)	VERY STRONG (5)	TOTAL	MEAN SCORE	D*
MEANING OF DEVELOPMENTAL DISABILITIES	PRE-TEST		23.5%(4)	58.8%(10)	5.9%(1)	11.8%(2)	100%(17)	3.06	.87
	POST-TEST			26.7%(4)	53.3%(8)	20%(3)	100%(15)	3.93	
HANDICAPS ENCOMPASSED BY THE LABEL "DEVELOPMENTAL DISABILITIES"	PRE-TEST		17.6%(3)	47.1%(8)	29.4%(5)	5.9%(1)	100%(17)	3.24	1.16
	POST-TEST			35.3%(6)	47.1%(8)	17.6%(3)	100%(17)	4.40	
LEGAL BASES FOR SERVICES AND FACILITIES TO ASSIST THE DEVELOPMENTAL DISABLED INDIVIDUAL	PRE-TEST	5.9%(1)	29.4%(5)	41.2%(7)	17.6%(3)	5.9%(1)	100%(17)	2.88	.79
	POST-TEST			40%(6)	53.3%(8)	6.7%(1)	100%(17)	3.67	
SPECIAL KNOWLEDGE AND SKILLS YOUR DISCIPLINE/ PROFESSION OFFERS TO ASSIST DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST		40%(6)	13.3%(2)	33.3%(5)	13.3%(2)	99.9%(15)	2.82	1.25
	POST-TEST		6.7%(1)	13.3%(2)	46.7%(7)	33.3%(5)	100%(15)	4.07	
VARIOUS DISCIPLINES/ PROFESSIONS WHICH FOSTER KNOWLEDGE AND SKILLS ESSENTIAL FOR ASSISTING DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST		35.3%(6)	41.2%(7)	23.5%(4)		100%(17)	2.88	1.19
	POST-TEST			26.7%(4)	40%(6)	33.3%(5)	100%(15)	4.07	
MINI TEAM (SYSTEMS) APPROACH TO WORKING WITH DEVELOPMENTAL DISABLED INDIVIDUALS	PRE-TEST	70.6%(12)	11.8%(2)	11.8%(2)	5.9%(1)		100%(17)	2.53	1.60
	POST-TEST		13.3%(2)	60%(9)	26.7%(4)		100%(15)	4.13	

Distribution of Scores for Pre-Test and Post-Test

Virginia Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental disability client population	Pre-test	11.8%(2)	64.7%(11)	11.8%(2)	11.8%(2)		100.1%(17)	3.24	.99
	Post-test		7.7%(1)	61.5%(8)	30.8%(4)		100%(13)	4.23	
Local agencies serving the developmentally disabled	Pre-test	23.5%(4)	58.8%(10)	5.9%(1)	11.8%(2)		100%(17)	3.06	.67
	Post-test		46.7%(7)	33.3%(5)	20%(3)		100%(15)	3.73	
State agencies serving the developmentally disabled	Pre-test	29.4%	47.1%(8)	11.8%(2)	11.8%(2)		100.1%(14)	3.06	.51
	Post-test	7.1%(1)	35.7%(5)	50%(7)	7.1%(1)		99.9%(14)	3.57	
Federal agencies serving the developmentally disabled	Pre-test	47.1%(8)	41.2%(7)	11.8%(2)			100.1%(17)	2.65	1.02
	Post-test	6.1%(1)	33.3%(5)	46.7%(7)	13.3%(2)		100%(15)	3.67	
Funding sources that may assist in the preparation of personnel for working in the developmental disability service delivery system	Pre-test	64.7%(11)	29.4%(5)	5.9%(1)			100%(17)	2.24	1.43
	Post-test	6.7%(1)	40%(6)	33.3%(5)	20%(3)		100%(15)	3.67	
Manpower needs in the developmental disability service delivery system	Pre-test	52.9%(9)	35.3%(6)	11.8%(2)			100%(17)	2.59	1.48
	Post-test		13.3%(2)	66.7%(10)	20%(3)		100%(15)	4.07	
Job classifications in the developmental disability service delivery system relevant to your discipline	Pre-test	33.3%(5)	40%(6)	26.6%(4)			99.9%(15)	2.59	1.34
	Post-test		33.3%(5)	40%(6)	26.7%(4)		100%(15)	3.93	

*D = Difference between means for pre-test and post-test

TRAINING MANUAL

Workshop participants were provided a Training Manual as part of the registration packet. Prepared in a leather bound loose leaf filler, the Training Manual was designed as both a training guide and a resource book. Prepared by Dr. Theodore Childs and Mrs. Marie L. Moore, Allied Health Department, Tuskegee Institute, the Manual provides a comprehensive summary of developmental disabilities.

- Section I - Needs and Resources: Specific manpower needs and available resources in the DD system are identified.
- Section II - Scope of Developmental Disabilities: Provides information on federal legislation, service delivery systems, normalization theory and deinstitutionalization, legal concept, service delivery concept, and other topics.
- Section III - Curriculum Development: Emphasis on developing methods of adopting or redesigning course materials, content, methods, field experiences, etc. to enhance curriculum for minorities relative to developmentally disabled populations.
- Section IV - Interinstitutional Cooperation: Reviews the major types of interinstitutional cooperative arrangements and discusses some limitations of cooperative arrangements.
- Selected Bibliography

WORKSHOP EVALUATION

The Workshop Participant Evaluation Form was designed to obtain information from participants regarding the effectiveness of the workshop. Participants were asked to rate the pre-registration package, keynote speaker, film, and the breakout sessions (Teams I, II, and III) on a scale of 1 to 10 with 1 indicating the lowest rating and 10 the highest rating. Comments were solicited regarding each of these components of the workshop. Further, participants were asked to indicate whether the workshop provided any new ideas or broadened their understanding of the DD service delivery system and to indicate their feelings regarding whether their institutions would develop personnel preparation programs in one of the areas serving the developmentally disabled. Finally, participants were asked to make suggestions for improving future workshops.

Alabama Workshop

The evaluation data indicate that the workshop was highly successful in achieving its preliminary goal of increasing participants' awareness and understanding of the DD service delivery system and of the need for black colleges and universities to provide programs to ehance the number of minority professionals serving the developmentally disabled.

All of the participants completing the evaluation form indicated that the workshop provided them with new ideas and broadened their understanding of the DD service delivery system. Eighty two percent of the respondents expressed the feeling that their institutions would implement a personnel preparation program in one of the areas serving the developmentally disabled.

In assessing the various components of the workshop, the participants rated all of the components very high with the exception of the film. The film only received a fair rating. The keynote speaker received the highest rating among the components. The mean (average) ratings for the workshop components are as follows: pre-registration package (8.2); keynote speaker (9.3); film (7.1); Team I (8.8); Team II (8.1); Team III (8.6); and overall team performance (8.5). Although the film recieved the lowest rating, it is important to note that the majority (58.3%) of the participants who viewed the film gave it a rating of 8 or above.

Texas Workshop

All of the participants completing the evaluation form indicated that the workshop provided them with new ideas and broadened their understanding of the DD service delivery system. Eighty-one percent of the respondents expressed the feeling that their institutions would implement a personnel preparation program in one of the areas serving the developmentally disabled.

In assessing the various components of the workshop, the participants' ratings ranged from fair to good. The film received the lowest rating and the pre-registration received the highest rating. The mean (average) ratings for the workshop components are as follows: pre-registration package (8.44); keynote speaker (7.85); film (7.00); Team I (7.93); Team II (8.00); Team III (8.12); overall team performance (8.01).

Virginia Workshop

All of the participants completing the Participant Evaluation Form indicated that the workshop provided them with new ideas and broadened their understanding of the DD service delivery system. Eighty-one percent of the respondents expressed the feeling that their institutions would

implement a personnel preparation program in one of the areas serving the developmentally disabled.

In assessing the various components of the workshop, the participants gave very high ratings to all of the components with the exception of two. The mean (average) ratings of the components are as follows: pre-registration package (9.44); keynote speaker (7.69); film (6.75); Team I (8.94); Team II (9.13); Team III (9.00); and overall team performance (9.02). It is obvious from these scores that the teams performed very well, and given the expertise of many of the participants' the mini team trainers should be very pleased with ratings.

Comments across Workshops

"This was one of the few conferences I have attended that provided so much valuable information that may be utilized by several disciplines."

"Timing needs working on. In my opinion we could have used more time for these sessions. All teams were good. Enough time was not allowed for dialogue."

"Excellent planning and preparation were evident in all aspects."

"Hassle-free neatly packaged; well prepared."

"Some participation activities may have added to the carry-over value."

"The film was very good in terms of illustrating the holistic apporach to DD."

"Film was good, but too long."

"The mini sessions were very helpful in providing information concerning how the DD related disciplines could work cooperatively in providing services to DD populations."

Suggestions for Improving Workshops

"Establish a network for sharing resources (i.e. information, materials, staff, etc.)."

"Expand the time of the workshop and include follow-up sessions."

"Provide for an open discussion on the feasibility of new program directions in the current atmosphere of budget cuts and the new federalism."

"There should be sessions where participants can exchange information about what they are doing at their institutions to expose studentsto the developmental disabilities field."

"Include counselors, mental health workers and other personnel from developmental agencies."

"Administrators should be invited to attend the workshops because in many cases programs are difficult to initiate unless they are introduced by the administration."

"Provide for an examination of the attractiveness of jobs in the DD system in relation to the time and money consumed in earning appropriate credentials."

ALABAMA CENTER FOR HIGHER EDUCATION

DEVELOPMENTAL DISABILITIES WORKSHOP

PARTICIPANT EVALUATION FORM

We need your honest and critical evaluation of this workshop in order to successfully determine its effectiveness, and to have advantage of your input concerning ways and means of improving future workshops.

To evaluate this workshop, please check (✓) the space provided for each breakout session you attended (including pre-registration package, keynote address and film) using the following rating scale of 1-10, with 10 being the highest. Place the number you selected from the rating scale that best describes the degree of beneficial knowledge, information, etc., you received in the rating space opposite each session you attended. Support each rating with a concise comment(s) in the space provided under each rating.

SCALE: Low 1 2 3 4 5 6 7 8 9 10 Hig

1. Pre-registration package: Rating _____
   Comment(s)

2. Keynote Speaker: Rating _____
   Comment(s)

3. Film: Rating _____
   Comment(s)

4. Breakout Sessions

   Team 1: Rating _____
   Comment(s)

   Team 2: Rating _____
   Comment(s)

   Team 3: Rating _____
   Comment(s)

5. Did this workshop provide you any new ideas or broaden your understanding of the Developmental Disabilities Service Delivery System?

   Yes _____

   No _____

6. Do you feel your institution will implement a personnel preparation program in one of the areas serving the developmentally disabled?

   Yes _____

   No _____ If not, why not?

7. If you have any suggestions that you believe would aid in the improvement of future workshops in order to make them more meaningful, please list:

ADDITIONAL REMARKS:

WORKSHOP PARTICIPANTS

Via informational leaflets and packets of information forwarded to the Presidents and Vice Presidents/Deans for Academic Affairs approximately 75 hbc's were invited to attend one of the three regional workshops as presented in the Table. Attached is a roster which includes only those faculty persons in attendance from hbc's.

Table 4.

Workshop	State	No. 4 year HBC's	No. Participating	No. Faculty Attending
ALABAMA	Alabama	7	7	23
	Florida	4	2	4
	Georgia	8	5	9
	Tennessee	6	3	8
TEXAS	Arkansas	3	2	2
	Louisiana	5	2	5
	Mississippi	5	4	7
	Oklahoma	1	1	3
	Texas	8	4	11
VIRGINIA	Kentucky	1	1	1
	North Carolina	10	2	8
	New Jersey	-	1	2
	Pennsylvania	2	1	1
	South Carolina	6	3	3
	Virginia	4	2	3
	Others	5	-	-
TOTALS		75	38	90

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